MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830 09860

Reg. Dist. No. 57

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Calvert

City or town: Barstow (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Calvert

City or town: Barstow (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Somerset Bowen

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Lillie B. Bowen

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Oct. 17, 1863

8. AGE: Years: 84 Months: 1 Days: 6 If less than one day: hrs. min.

9. Birthplace: Calvert Co., Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Fletcher Bowen

13. Birthplace: Md

MOTHER — 14. Maiden name: Elizabeth Williams

15. Birthplace: Md

16. Informant: Mrs Oscar Bowen

Address: Barstow, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 25, 1947 (month) (day) (year)

Cemetery or crematory: Central

Location: Barstow, Md

18. Funeral director: A. A. Harkness & Son

Address: Mutual, Md

19. 11-25 1947 (Date rec'd by registrar) W. W. Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23, 1947, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 19 to 19

and that I last saw him alive on Nov 23 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Prince Frederick Md Date signed

09861

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Calvert
City or town: Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Walter Brooks.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	X

6.(b) Name of husband or wife: Frances Brooks
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Sept 25 1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59				

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Benjamin Brooks
13. Birthplace: Md

MOTHER
14. Maiden name: Sussie Wall
15. Birthplace: Md.

16. Informant: James Brooks
Address: Prince Frederick, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-22, 47 (month) (day) (year)
Cemetery or crematory: Mt Olive
Location: Calvert

18. Funeral director: P. E. Sewell
Address: Prince Frederick, Md

19. 11-21 19 47 (Date rec'd by registrar) H. W. Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-20, 19 47, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Hypertension c.v.d	
Due to: Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jos Villarreal M.D.
M. D. or other
Address: S. Leonard Md Date signed Nov 21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09862

830

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:
County: Calvert County
City or town: Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Calvert County Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ~~Washington D.C.~~ Calvert
City or town: North Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr Robert E. Dennison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1879

8. AGE:

Years	Months	Days	If less than one day
68	5	11	..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: William E. Dennison
13. Birthplace: Wash. D.C.

MOTHER
14. Maiden name: Flora Cook
15. Birthplace: Wash. D.C.

16. Informant: Miss D.C. Dennison
Address: 1701 - 16th N.W., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18, 1947 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Wash. D.C.

19. Funeral director: Joseph Gawler's Sons
Address: Wash. D.C.

19. (Date rec'd by registrar) 11-16 19 47 — N. W. Ward, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 19 47, at 8:53 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 19 47, to November 16 19 47
and that I last saw h[illegible] alive on Nov 15 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Page Pratt, M. D. or other
Address: Prince Frederick Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09863

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert County

City or town Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Calvert Co. Hospital

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert

City or town Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hattie Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 10 - 1896

8. AGE: Years	Months	Days	If less than one day
51	7	7	..... hrs. ..... min.

9. Birthplace Unknown

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Hall

13. Birthplace Unknown

MOTHER 14. Maiden name Margaret Powell

15. Birthplace Unknown

16. Informant Hattie Hall

Address Mitchellville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/19/47 (month) (day) (year)

Cemetery or crematory FRIENDSHIP

Location FRIENDSHIP, Md

18. Funeral director T. A. Hardesty & Son

Address Golesville, Md.

19. 11-17 1947 (Date rec'd by registrar) N. W. Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1947 at 2:32 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/1 1947, to 11/17 1947

and that I last saw h[illegible] alive on 11/16 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed 11/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 f

09864

Reg. Diat. No. 51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Calvert

City or town: Owensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Calvert

City or town: Owensville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Wm Hawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	W

6.(b) Name of husband or wife: Sarah Hawkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1873

8. AGE: Years: 74 Months: ~~Mo~~ Days: 25 If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Jno Hawkins

13. Birthplace: Md

MOTHER 14. Maiden name: Susan Giles

15. Birthplace: Md

16. Informant: Sarah Hawkins

Address: Owensville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-47 (month) (day) (year)

Cemetery or crematory: Coopers Chapel

Location: Calvert

18. Funeral director: P. E. Sewell

Address: Prince Frederick

19. 11-28 19 47 (Date rec'd by registrar) N.W. Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma of Liver	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. W. Ward M. D. or other

Address: Owensville Date signed 11/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

838 09865

Reg. Dist. No. 51

1. PLACE OF DEATH:
County Calvert
City or town Olivett md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Calvert
City or town Olivett
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rachel A Hollis.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	X

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1884

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace md (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Mathew Sutton.
13. Birthplace md
MOTHER 14. Maiden name Sarah Johnson.
15. Birthplace md
16. Informant Rita Sutton
Address Olivett, md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-17-47 (month) (day) (year)
Cemetery or crematory Eastern Chapel
Location Calvert, Co.
18. Funeral director P. E. Sewell
Address Prince Frederick, Md.
19. 11-17 1947 (Date rec'd by registrar) N. W. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1947, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Central embolism	
Due to Essential hypertension	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE [signature] M. D. or other
Address St Leonard Md Date signed Nov 17, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 09866

Reg. Dist. No. 50

1. PLACE OF DEATH:

County: Calvert

City or town: Solomons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Calvert

City or town: Solomons

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME WILLIAM - Henry - KOPP

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: MAUD - KOPP.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 26 - 1866

8. AGE: Years	Months	Days	If less than one day
80	11	7	hrs. min.

9. Birthplace: Solomons, Maryland (Town, county, and state)

10. Usual occupation: Carpenter -

11. Industry or business: Shipyard

FATHER 12. Name: Wilhelm Kopp

FATHER 13. Birthplace: Darmstadt - Germany

MOTHER 14. Maiden name: Caroline Gertle -

MOTHER 15. Birthplace: Darmstadt - Germany

16. Informant: Adolph Kopp

Address: Solomons, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 6. 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore - Maryland

18. Funeral director: A. A. Harkness & Son

Address: Mutual - Maryland

19. Nov 3 1947 (Date rec'd by registrar) Dr. E. S. Coster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November - 3 1947, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1945 to Nov. 3 1947 and that I last saw him alive on Nov. - 3 - 1947

	DURATION
Immediate cause of death	
Chronic Myocarditis	3 yrs
Due to	
Senile Degeneration	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. S. Coster - M. D. M. D. or other

Address: Solomons, Md Date signed: 11/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

09867

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:
County Calvert
City or town Lower Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Calvert.
City or town Lower Marlboro md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Amanda Ray (Coates)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	X

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1837

8. AGE: Years 110 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace md (Town, county, and state)

10. Usual occupation Domestic.

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden name Minnie Chase.
15. Birthplace md.

16. Informant Gladys Jones.
Address Lower Marlboro, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-23-47 (month) (day) (year)
Cemetery or crematory St Johns.
Location Calvert

18. Funeral director P.E. Sewell
Address Prince Frederick

19. 11-22 1947 H Wagner Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1947, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Arteriosclerosis	
Cardiac disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Roger Jr M.D. M. D. or other
Address Prince Frederick Date signed 11-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95c

09868

Reg. Dist. No. 150

1. PLACE OF DEATH:

County: Calvert

City or town: Solomons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2 hour

Hospital, Institution, or street address where death occurred: died on boat before docking

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New York County:

City or town: New York City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Riverside Drive

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Murray C. Rosenthal

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mildred Rosenthal

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10 - 1891

8. AGE: Years	Months	Days	If less than one day
56	4	10	hrs. min.

9. Birthplace: New York State (Town, county, and state)

10. Usual occupation: Factory owner - Dresses

11. Industry or business

FATHER — 12. Name: Micheal Rosenthal

13. Birthplace: Roumania

MOTHER — 14. Maiden name: Caroline Wassermann

15. Birthplace: Roumania

16. Informant: Edward Brodsky

Address: 1449 - E. 26th - Brooklyn, N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24-1947 (month) (day) (year)

Cemetery or crematory: Washington Cemetery

Location: Brooklyn - New York

18. Funeral director: A. A. Harkness Son

Address: Mutual - Maryland

19. 11/20/47 19.... Dr. E. S. Coster (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1947 at 4-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death: Cardiac Disease

DURATION

Due to: arrived at Solomons, Md

Due to: on boat - (Cruise) from New York, going to Florida -

Other conditions: Heart attack 1/2 hr. before boat docked

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. E. S. Coster M. D. or other

Address: Solomons, Md Date signed: 11/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15